Lisa B. Kelly, LCSW, LLC
401 E. Colfax Ave, Suite 114
South Bend, IN 46617

REGISTRATION FORM

(please complete and bring with you to your intake appointment)

Today's Date: _____ Who referred you to my practice?
_____

Patient Information

Last Name:_____First name: _____

Date of Birth: _____

Cell phone: _____ Home phone: _____

Address: _____

City, State,
Zip_____

Email address: _____

I give my consent for a text reminder to be sent to my cell phone 24 hours prior to future appointments: (sign here):
_____

Insurance provider: _____

Subscriber's name: _____

Subscriber's DOB: _____

Subscriber's Employer: _____

Doctor's name, practice location and phone number:
_____

_____
__

Emergency Contact (Name, phone number relationship to you): _____

Consent for treatment and fee agreement: I consent to receive services from Lisa B. Kelly, LCSW and I agree to pay for services rendered that are not covered by the above-mentioned insurance company. I authorize payments to be paid directly to Lisa B. Kelly, LCSW, LLC. I also understand that I am financially responsible for any balance due on my account. I understand that I will pay all copays and deductible amounts at the time of service. I also authorize Lisa B. Kelly, LCSW, LLC and/ or my insurance company to release any information necessary and/ or required to process my claims.

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(sign here): _____Date: _____